STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445288	A. BUILDING _____ B. WING _____	10/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTSVILLE MANOR	287 BAKER STREET HUNTSVILLE, TN 37756

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During the annual Recertification survey and complaint investigations (#32220, #32378) conducted on October 30, 2013, at Huntsville Manor, no deficiencies were cited in relation to complaint #32378, under 42 CFR Part 43, Requirements for Long Term Care.	F 000	F166 483.10 (f)(2) Right to Prompt Efforts To **Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:** 1. A grievance/complaint was received and investigated on October 29, 2013 by the the Social Service Director with resident #11. A check in the amount of $48 was Written on 10/31/13 and distributed to resident #11. Completion date: October 31, 2013 **Identify other residents having the potential to be affected by the same deficient practice and what corrective action taken:** 2. 100% audit of interviewable residents in the facility was completed by Social Service Director, Admissions Director, and Activity Director on October 29, 2013 to ensure no complaints of missing money by any of our residents. 100% interview of all staff to ensure if knowledge of missing money or any appropriate item by all Social Service Director and all management staff began on October 29, 2013. Inservice was conducted by Risk Manager on "Reporting of Grievances/Complaints" with all staff that began on October 29, 2013. Completion date: November 1, 2013 **Measures/systematic changes put in place to ensure the deficient practice does not recur:** 3. In-service conducted by the Risk Manager with all facility staff That began on October 29, 2013 on "Reporting of Grievances/Complaints." Completion date: November 1, 2013	
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to resolve a grievance of missing money for one resident (#11) of twenty-four residents reviewed. The findings included: Resident #11 was admitted to the facility on July 19, 2013, with diagnoses including Congestive Heart Failure, Pneumonia, Atrial Fibrillation, Hypertension, and Chronic Kidney Disease. Observation and interview on October 28, 2013, at 3:32 p.m., in the resident's room, revealed resident #11 sitting in a wheelchair. Interview with the resident revealed the resident had forty-eight dollars missing around the time of admission to the facility on July 19, 2013. Continued interview revealed the resident had told staff about the missing money and no one had addressed the	F 166		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carla Putnam | TITLE: Administrator | (X6) DATE: 11-12-13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 166	Continued From page 1 concern. Interview with the Assistant Director of Nursing (ADON) and Charge Nurse #1 on October 29, 2013, at 4:28 p.m., at the nurse's station, confirmed the resident told Charge Nurse #1 about the missing money. Continued interview with the Charge Nurse revealed the Charge Nurse contacted the Director of Nursing regarding the missing money. Interview with the Director of Nursing (DON) and the ADON on October 29, 2013, at 4:36 p.m., in the DON office, confirmed the DON was aware of the money missing and told the Charge Nurse to contact Social Services. Interview with the Administrator and DON on October 29, 2013, at 4:45 p.m., in the Administrator's office, confirmed the facility was aware and failed to resolve the grievance for resident #11.	F 166	**Monitoring of corrective action to ensure the deficient practice will not recur;** 4. Social Service Director and Risk Manager will interview 5 residents per week for 4 weeks to ensure no complaints of missing personal property. (Ongoing) Overall findings will be reported to the NHA immediately when policy is not adhered to. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy. Report of overall findings and subsequent disciplinary action, if applicable will be reported to the facility Quality Assurance (QA) Committee (consisting of DON, Medical Director, ADON, NHA, Risk Manager, MDSC, Pharmacy Consultant, Registered Dietician, Wound Care Nurse, and Social Service Director) to review the need for continued intervention or amendment of plan.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278	5. Completion date:	11/1/13

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F 278	Continued From page 2 Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to ensure an accurate Minimum Data Set (MDS) related to weight loss for one resident (#94) of twenty-four residents reviewed. The findings included: Resident #94 was admitted to the facility on March 27, 2013, with diagnoses including Hemiplegia (Paralysis) to the Left Side, Malaise, Lack of Coordination, Hypertension, Esophageal Reflux, and Psychosis. Medical record review of the quarterly MDS dated September 21, 2013, revealed the resident was severely cognitively impaired, required extensive assistance with activities of daily living, had weight loss, and was on a physician prescribed weight loss program.	F 278	F278 483.20 (g)-(j) Assessment Accuracy Coorindation/Certified **Corrective action(s) accomplished for those residents found to have been affected by the deficient practice;** 1. The MDS Assessment of Resident #94 has been corrected and accurately reflects the resident's status. Completion date: Nov 5, 2013 **Identify other residents having the potential to be affected by the same deficient practice and what corrective action taken:** 2. 100% audit of residents charts has been completed by the MDS Coordinator, Dietary Manager, Social Service Director, and Activity Director to verify all residents MDS assessments accurately reflect the resident's status. Completion date: November 15, 2013 **Measures/systematic changes put in place to ensure the deficient practice does not recur;** 3. In-service conducted by the Administrator with the MDSC, Dietary Manager, Social Service Director, and the Activity Director on "Ongoing Assessment of Resident's Progress/Status". Completion date: November 10, 2013 Physician orders, history & physical, psychological and/or behavior updates are reviewed in regularly scheduled morning meetings by MDSC to verify accuracy of MDS assessment to assure reflection of resident's status.	

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F 278	Continued From page 3 Review of the resident's weight record revealed the resident's weights were: May 7, 2013, 125 pounds; June 4, 2013, 125 pounds; July 9, 2013, 126 pounds; August 6, 2013, 116 pounds; September 2, 2013, 115 pounds; and, October 7, 2013, 116 pounds. Medical record review of a dietician note dated October 3, 2013, revealed, "...stable from last week..." Medical record review of a dietician note dated October 25, 2013, revealed, "...resident had one pound decreased weight...resident continue on tube feedings...family notified...MD (medical doctor) notified...will continue to monitor..." Observation on October 29, 2013, at 3:40 p.m., in the resident's room, revealed the resident was receiving Two Cal tube feedings at 40 cubic centimeters per hour (cc/hr) by pump, per the Percutaneous Endoscopic Gastrostomy (PEG) tube. Observation on October 30, 2013, at 12:30 p.m., in the resident's room, revealed the resident sitting up in the wheel chair and the tube feeding infusing at 40cc/hr. Interview with Registered Nurse (RN) #1 on October 30, 2013, at 8:45 a.m., in the nurse's station, revealed, "...resident had weight loss but has stabilized with the change in tube feedings..." Interview with the Assistant Director of Nursing (ADON) on October 30, 2013, at 1:15 p.m., in the nurse's station, confirmed, "...the resident had a weight loss in the past and has not been placed on a physician prescribed weight loss program..."	F 278	**Monitoring of corrective action to ensure the deficient practice will not recur;** 4. DON and ADON (or Risk Manager in Absence of DON or ADON) will audit 5 resident charts per week for 4 weeks to assure accurate reflection of resident's status of MDS assessment. Overall findings will be reported to the NHA immediately when policy is not adhered to. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy. Report of overall findings and subsequent disciplinary action, if applicable will be reported to the facility Quality Assurance (QA) Committee (consisting of DON, Medical Director, ADON, NHA, Risk Manager, MDSC, Pharmacy Consultant, Registered Dietician, Wound Care Nurse, and Social Service) Director) to review the need for continued intervention or amendment of plan. 5. Completion date:	11/15/13

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F 278	Continued From page 4 Interview with the MDS coordinator on October 30, 2013, at 1:30 p.m., in the nurse's station, confirmed the resident was not on a physician prescribed weight loss program and the MDS was inaccurate.	F 278		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medial record review, observation and interview, the facility failed to provide a safe environment by ensuring bed wheels were locked for one resident (#83) of twenty-four residents reviewed. The findings included: Medical record review revealed resident #83 was admitted to the facility on April 11, 2012, with diagnoses including Paralysis, Dysphagia, Lack of Coordination, Chronic Obstructive Pulmonary Disease (COPD), Hypertension, Tremors, Dementia and Depression. Medical record review of the quarterly Minimum Data Set (MDS) dated August 8, 2013, revealed the resident scored a thirteen on the Brief	F 323		

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F 323	Continued From page 5 Interview for Mental Status (BIMS) (indicating the resident was cognitively intact) and required assistance with activities of daily living. Medical record review of a nurse's note dated October 26, 2013, at 9:30 a.m., written by Licensed Practical Nurse (LPN) #1, revealed "...res (resident) was in...room when...chair alarm starting alarming...a CNA (Certified Nurse Aide) went into the room and res was lying in the floor with the bed scooted toward the wall...no injury noted...resident assisted into the bed by staff...no distress noted..." Review of the facility investigation dated October 26, 2013, at 9:30 a.m., revealed, "...res tried to transfer from wheel chair to bed when...put weight on the bed it slid, causing...to fall into the floor..." Review of a facility witness statement dated October 26, 2013, with no time, written by Registered Nurse (RN) #2 revealed, "...was called to room...noted resident sitting on buttock between wheel chair and bed...wheelchair was sitting behind...with the wheels locked...the foot of...bed was scooted toward the window...noted the bed was not locked down...rolled down the bed stabilizers and lifted the wheels so that the bed was more stable..." Medical record review of a Fall Risk Assessment, dated October 26, 2013, revealed the resident scored a twenty on the assessment (above 10 represents high risk). Interview with LPN #1 on October 30, 2013, at 10:30 a.m., in the nurse's station, revealed, "...resident has tremors...on October 30, 2013 the	F 323	F323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES **Corrective action(s) accomplished for those residents found to have been affected by the deficient practice;** 1. Resident #83 has a bed with lock in place on the resident bed. Completion date: 10/30/13 **Identify other residents having the potential to be affected by the same deficient practice and what corrective action taken:** 2. 100% facility audit was completed by the Risk Manager and Maintenance Director to ensure all beds had a locking mechanism in place and functional with each resident bed. Completion date: 10/30/13 **Measure/systematic changes put in place to ensure the deficient practice does not recur:** 3. In-service began on October 30, 2013 by the Risk Manager of all staff ensuring beds are in locked position for safety. Completion date: 11/14/13 Maintenance Director will conduct weekly preventative maintenance rounds and provide a monthly report at monthly meeting.	

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F 323	Continued From page 6 resident was transferring from the wheelchair to the bed...resident put weight on the bed and the bed shifted...the wheels were on the floor when the bed shifted...not sure if the bed was locked...has history of falls..." Interview with the Assistant Director of Nursing (ADON) on October 30, 2013, at 11:35 a.m., in the conference room, confirmed the resident's bed wheels were not locked when the resident transferred from the wheelchair to the bed.	F 323	**Monitoring of corrective action to ensure the deficient practice will not recur;** 4. NHA will assure compliance by weekly review of preventative maintenance log for routine maintenance and care of beds in the facility for 4 weeks to ensure beds are in a functional locked position. Results will be presented to the Quality Assurance Committee. Overall findings will be reported to NHA immediately when schedule and/or maintenance and care of beds are not be followed. Failure to adhere to the routine maintenance and care for beds will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy. Report of overall findings and subsequent disciplinary action, if applicable, will be reported to the facility Quality Assurance (QA) Committee (consisting of Medical Director, Pharmacy Consultant, Central Supply Clerk, Wound Care Nurse, DON, ADON, SSD, NHA, Risk Manager, MDSC, LPN, Social Service Director) to review the need for continued intervention or amendment of plan. 5. Completion date:	11/14/2013
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, review of Food Temperature Records, review of facility policy, and interview, the facility failed to serve hot food at or above 135 degrees Fahrenheit (F) for one of one meal observations. The findings included: Observation on October 28, 2013, at 12:00 p.m., in the kitchen, with the dietary manager of the mid-day tray line, revealed the dietary manager	F 371		

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F 371	Continued From page 7 obtained food temperatures of pureed turkey, 120 degrees farhenheit (F) and mashed potatoes, 110 degrees F. Continued observation revealed the food was placed on resident trays and served to the resident's in the dining room. Review of the Food Temperature Record for the lunch meal on October 28, 2013, revealed the food temperature for the pureed turkey was 170 degrees F when put on the steam table at the beginning of food service, and the mashed potatos was 205 degrees F. Review of facility policy, Safe Food Temperatures, with no date, revealed, "...(2) the food should first be cooked to its proper internal temperature...poultry 165 degrees Fahrenheit... (3) after the food has been cooked to the proper temperature it must be on the steam table at 140 degrees Fahrenheit or higher..." Interview with the Dietary Manager on October 28, 2013, at 12:15 p.m., in the kitchen, confirmed, "...food should be at least 140 degrees F..." Continued interview with the dietary manager confirmed the food temperature of the pureed turkey was 120 degrees F and the mashed potatoes was 110 degrees F on the steam table and the food was served to the residents. C/O 32220	F 371	F371 483.35(i)(2) Sanitary Conditions- Food Prep and Service **Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:** 1. Cook (Sexton) received written disciplinary on October 28, 2013 by the Dietary Manager. Completion date: 10/28/13 **Identify other residents having the potential to be affected by the same deficient practice and what corrective action taken:** 2. The Dietary Manager ensured that all foods served met the required food temps in accordance with facility policy. Completion date: 10/28/13 **Measures/systematic changes put in place to ensure that the deficient practice does not recur;** 3. In-service conducted by Dietary Manager on "Safe Food Temps" began On October 28, 2013 with Dietary Department staff before beginning of their next shift. Completion date: 10/31/13 Dietary Manager will monitor random food items "daily" (in her absence the dietary backup) to ensure the food is being maintained at the proper temperature and recording of temperatures on file in accordance with the facility policy.	
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside			

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F 411	Continued From page 8 resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to obtain dental services for one resident (#31) of twenty-four residents reviewed. The findings included: Resident #31 was admitted to the facility on February 14, 2013, with diagnoses including Hypertension and Chronic Lung Disease. Observation and interview with resident #31 on October 21, 2013, at 9:50 a.m., in the resident's room, revealed the resident had few natural teeth, and the teeth were darkened and decayed. Interview with the resident revealed, when asked if the resident's teeth hurt, the resident stated, "They have been like this a long time...only hurt when I try to bite into something." Review of the Social Progress Notes dated August 8, 2013, revealed, "...I asked (Resident #31) if (resident) was having any problems with...teeth. (Resident #31) said...didn't have many teeth left..."	F411	**Monitoring of corrective action to ensure the deficient practice will not recur;** 4. NHA will assure compliance by weekly review of temperature log and random food items checked through tray line service to ensure the food is being maintained at the proper temperatures for 4 weeks in accordance with facility policy. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy. Report of overall findings and subsequent disciplinary action, if applicable, will be reported to the facility Quality Assurance (QA) Committee (consisting of DON, Medical Director, ADON, NHA, Risk Manager, MDSC, Pharmacy Consultant, Registered Dietician, Wound Care Nurse, SSD) to review the need for continued intervention or amendment of plan. 5. Completion date: F411 483.55(a) Routine/Emergency Dental Services in SNFs **Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:** 1. Pain Assessment completed on 10/30/13 for resident #31 by the Assistant Director of Nursing indicating a 0 on a scale of 10.	11/1/13

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F 411	Continued From page 9 Review of the Dietary Progress note dated October 25, 2013, revealed, "...Diet (changed) to mechanical texture...Resident was complaining of not being able to chew foods..." Interview with the Social Service Director (SSD) on October 30, 2013, at 10:00 a.m., in the Social Services office, revealed the SSD was aware resident #31 had tooth decay. When asked if the SSD had made an appointment for resident #31, the SSD stated, "No I have not." Interview with the Director of Nursing (DON) on October 30, 2013, at 12:50 p.m., in the DON's office, confirmed the resident was in need of dental care and had not been to the dentist.	F 411	Dental appointment scheduled for resident #31 by the Social Service Director for November 25, 2013. Ombudsman notified on November 6, 2013 of resident #31 refusal for treatment and advised of the risk of not getting the treatment done if continues to refuse by SSD/ Completion date: 11/06/13 **Identify other residents having the potential to be affected by the same deficient practice and what corrective action taken:** 2. SSD conduct 100% facility audit to ensure all residents have obtained routine and/or 24 hour emergency dental care as needed in accordance with facility policy. Completion date: 11/13/13 **Measures/systematic changes put in place to ensure that the deficient practice does not recur;** 3. In-service began on November 7, 2013 by NHA with Social Service Director, and licensed staff on "Routine Dental Care" and "Emergency Dental Care" Policy. Completion date: 11/15/13 Social Service Director will maintain Dental tracking log of all residents routine and emergency dental care appointments. (Ongoing)	

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N 000	Initial Comments During the annual Licensure survey and complaint investigations (#32220, #32378) conducted on October 30, 2013, at Huntsville Manor, no deficiencies were cited under 1200-8-6, Standards for Nursing Homes.	N 000	**Monitoring of corrective action to ensure the deficient practice will not recur;** 4. DON will assure compliance by weekly review of dental log to ensure residents have had a yearly routine dental and/or emergency dental care as needed for 4 weeks in accordance with facility policy. Overall findings will be reported to NHA immediately. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy. Report of overall findings and subsequent disciplinary action, if applicable, will be reported to the facility Quality Assurance (QA) Committee (consisting of DON, Medical Director, ADON, NHA, Risk Manager, MDSC, Pharmacy Consultant, Registered Dietician, Wound Care Nurse, SSD) to review the need for continued intervention or amendment of plan. 5. Completion date:	11/15/13

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 11-12-13